The California Managed Risk Medical Insurance Board
1000 G Street, Suite 450
Sacramento, CA 95814
(916) 324-4695 FAX: (916) 324-4878

March 27, 2009

NOTICE OF PROPOSED RULEMAKING
ER-01-09

TITLE 10: CALIFORNIA CODE OF REGULATIONS
CHAPTER 5.8 HEALTHY FAMILIES PROGRAM

AMEND SECTION 2699.6805

NATURE OF PROCEEDING

NOTICE IS HEREBY GIVEN that the Managed Risk Medical Insurance Board (MRMIB) is proposing to take the action described in the Informative Digest.

A public hearing regarding this proposal will be held on May 11, 2009, at 1:30 p.m., at 1000 G Street, Suite 450, Sacramento, CA 95814.

Following the public hearing MRMIB may thereafter adopt the proposal substantially as described below or may modify the proposal if the modifications are sufficiently related to the original text. With the exception of technical or grammatical changes, the full text of any modified proposal will be available for 15 days prior to its adoption from the person designated in this Notice as contact person and will be mailed to those persons who submit written comments related to this proposal, or who provide oral testimony at the public hearing, or who have requested notification of any changes to the proposal.

Notice is also given that any interested person, or his or her authorized representative, may submit written comments relevant to the proposed regulatory action to the:

Managed Risk Medical Insurance Board
Attn: Dianne Knox
1000 G Street, Suite 450
Sacramento, CA 95814

Comments may also be submitted by facsimile (FAX) at (916) 445-0898 or by e-mail to dknox@mrmib.ca.gov. Comments must be received by no later than 5:00 p.m. on May 11, 2009.

AUTHORITY AND REFERENCE

Authority: Insurance Code section 12693.21
Reference: Insurance Code sections 12693.21 and 12693.37

INFORMATIVE DIGEST/POLICY STATEMENT OVERVIEW

Policy Statement:

The objectives of the proposed regulations are to (1) provide the Board with the ability to comply with regulations to determine, by county, the plan that has the most Traditional and Safety Net providers in its network in order to designate the Community Provider Plan, (2) provide Healthy Families Program (HFP) applicants and members with a choice of low cost plans, (3) avoid disruption to families, and (4) avoid needless and excessive programmatic costs.

Existing Law:

In August 1997, the Federal Government established a new program, the State Children's Health Insurance Program (SCHIP), by adding Title XXI to the Social Security Act. The program provides health care services to uninsured, low-income children. The program is targeted to serve children whose family's income, although low, is too high to qualify for the Title XIX Medicaid Program, called Medi-Cal in California. The Legislature passed and the Governor signed AB 1126, resulting in Chapter 623, Statutes of 1997 (AB 1126). Under that law, California took the option of both expanding its Medi-Cal Program and establishing a new stand alone children's health insurance program, the Healthy Families Program (HFP). HFP currently provides health insurance for more than 900,000 low-income children. The Department of Health Care Services (DHCS) administers the Medi-Cal expansion through its own Regulations. The Managed Risk Medical Insurance Board (MRMIB) administers the HFP. The basic structure of the HFP is set out in regulations approved by the Office of Administrative Law, which established Chapter 5.8 of Title 10 of the California Code of Regulations.

MRMIB administers the HFP to provide health insurance coverage for low-income uninsured children. The coverage is provided by contracting with health plans. By statute, MRMIB must take steps to assure a range of choices are available to applicants and it must include plans whose provider networks include contracts with traditional and safety net providers. In each county, the Board must designate a community provider plan. Applicants selecting a community provider plan are given a family contribution discount.

LOCAL MANDATE

This proposal does not impose a mandate on local agencies or school districts.

FISCAL IMPACT ESTIMATES

This proposal does not impose a mandate on local agencies or school districts for which reimbursement would be required pursuant to Part 7 commencing with Section 17500 of

Division 4 of the Government Code. This proposal does not impose other nondiscretionary cost or savings on local agencies, or cost or savings in federal funding to the state.

COSTS OR SAVINGS TO STATE AGENCIES
No additional costs or savings to state agencies are anticipated.

BUSINESS IMPACT/SMALL BUSINESS
The proposed regulation will not have a significant statewide adverse economic impact directly affecting business/small business, including the ability of California businesses to compete with businesses in other states, since it would simply give the Managed Risk Medical Insurance Board flexibility as to when the Community Provider Plan designation must occur.

ASSESSMENT REGARDING EFFECT ON JOBS/BUSINESSES
The MRMIB has determined that this regulatory proposal will not have any impact on the creation of jobs or new businesses or the elimination of jobs or existing businesses or the expansion of businesses in the State of California

COST IMPACTS ON REPRESENTATIVE PERSON OR BUSINESS
The MRMIB is not aware of any cost impacts that a representative private person or business would necessarily incur in reasonable compliance with the proposed action.

EFFECT ON HOUSING COSTS: None

ALTERNATIVES
The MRMIB must determine that no reasonable alternative considered by the agency, or that has been otherwise identified and brought to the agency's attention, would be more effective in carrying out the purpose for which the adoption of this regulation is proposed.

CONTACT PERSONS
Inquiries concerning the proposed adoption of this regulation and written comments may be directed to:

Dianne Knox
Managed Risk Medical Insurance Board
1000 G Street, Suite 450
Sacramento, CA 95814
(916) 324-0592

or

Randi Turner
Managed Risk Medical Insurance Board
1000 G Street, Suite 450

Sacramento, CA 95814
(916) 327-8243

INITIAL STATEMENT OF REASONS
The MRMIB has prepared an initial statement of reasons for the proposed action and has available all the information upon which the proposal is based.

TEXT OF PROPOSAL
Copies of the exact language of the proposed regulations and of the initial statement of reasons, and all of the information upon which this proposal is based, may be obtained upon request from the Managed Risk Medical Insurance Board at 1000 G Street, Suite 450, Sacramento, CA 95814. These documents may also be viewed and downloaded from the MRMIB website at www.mrmib.ca.gov

AVAILABILITY AND LOCATION OF THE FINAL STATEMENT OF REASONS AND RULEMAKING FILE
All the information upon which the proposed regulations are based is contained in the rulemaking file which is available for public inspection by contacting the person named above.

You may obtain a copy of the final statement of reasons once it has been prepared by making a written request to the contact person named above.

WEBSITE ACCESS
Materials regarding this proposal can be found at www.mrmib.ca.gov

STATE OF CALIFORNIA
MANAGED RISK MEDICAL INSURANCE BOARD
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SACRAMENTO, CA 95814

TITLE 10, INVESTMENT, CALIFORNIA CODE OF REGULATIONS
CHAPTER 5.8 MANAGED RISK MEDICAL INSURANCE BOARD
HEALTHY FAMILIES PROGRAM
AMEND SECTION 2699.6805

INITIAL STATEMENT OF REASONS

INTRODUCTION

In August 1997, the Federal Government established a new program, the State Children's Health Insurance Program (SCHIP), by adding Title XXI to the Social Security Act. The program provides health care services to uninsured, low-income children. The program is targeted to serve children whose family's income, although low, is too high to qualify for the Title XIX Medicaid Program, called Medi-Cal in California. The Legislature passed and the Governor signed AB 1126, resulting in Chapter 623, Statutes of 1997 (AB 1126). Under that law, California took the option of both expanding its Medi-Cal Program and establishing a new stand alone children's health insurance program, the Healthy Families Program (HFP). HFP currently provides health insurance for more than 900,000 low-income children. The Department of Health Care Services (DHCS) administers the Medi-Cal expansion through its own Regulations. The Managed Risk Medical Insurance Board (MRMIB) administers the HFP. The basic structure of the HFP is set out in regulations approved by the Office of Administrative Law, which established Chapter 5.8 of Title 10 of the California Code of Regulations.

Through HFP, MRMIB provides children's health insurance coverage to eligible children whose family incomes are at or below 250% of the federal poverty level net of applicable deductions and who are ineligible for Medi-cal because their family income exceeds Medi-Cal income eligibility limits. (Insurance Code section 12593 et seq.) MRMIB provides the coverage to eligible children by contracting with health plans. (Insurance Code section 12693.26.) Participating health plans, in turn, contract with providers to provide the medical services. In the selection of participating plans, the Board must include plans that have contracts with traditional and safety net (T&SN) providers. (Insurance Code section 12693.37(b).) The T&SN providers are those which historically serve low

income and uninsured children, such as free or rural health clinics and county-owned and operated general acute care hospitals.[1]

In each county, the Board must designate a community provider plan (CPP) that is the participating health plan that has the highest percentage of T&SN providers in its network.[2] Applicants selecting a CPP receive a family contribution discount on their premiums. (Insurance Code section 12693.43(d).) The discounted premium is subsidized by MRMIB. The process gives an incentive for the plans to compete for the CPP designation because the family contribution discount encourages applicants to choose the CPP.

The CPP designation process is intended to promote important goals in providing health care to low-income children: (1) stability for the T&SN providers, which historically provide services to HFP-eligible children, (2) continuity of care for newly enrolled HFP subscribers because such subscribers are likely to have been uninsured and, therefore, more likely to have used T&SN providers, and (3) provision of care by providers that have cultural and linguistic competencies appropriate to the HFP-eligible population since T&SN providers are more likely to be located in areas which reflect HFP eligible subscribers' cultural and linguistic characteristics.

The HFP regulations set forth the process for the health plans' submission of data that MRMIB considers to determine which plan has the highest percentage of T&SN providers.[3] (Cal Code, title 10, section 2699.6805.) Each year, the Board compiles and makes available a list for each county of all Child Health and Disability Prevention Program (CHDP), clinic, and hospital T&SN providers that meet specified criteria. The CHDP list is compiled using data from the CHDP Paid Claims Tape and the clinic list is compiled using data from the Medi-Cal Paid Claims Tape. The hospital list is compiled using data from the Department of Health Care Services (DHCS) and the Office of Statewide Health Planning and Development (OSHPD). Plans have an opportunity to request revisions to the lists if the plans can demonstrate that a provider not on the list meets the criteria listed in the regulations (Cal. Code sections 2699.805(d)(1), (2) and (3).) After the revision period has expired, the Board compiles and makes available a final list for each county of CHDP, clinic and hospital T&SN providers. Each plan then uses the final list to indicate which of the providers are contracted with the plan. Finally, MRMIB calculates a T&SN score for each plan in each county and the plan with the highest score is designated the CPP.

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[1] The types of T&SN providers are more fully described in section 2699.6805(c).

[2] The term "community provider plan" means the participating health plan in each geographical area that has been designated by the board as having the highest percentage of traditional and safety (T&SN) providers in its provider network. (Ins. Code section 12693.045.) The Board has determined that the applicable geographic area for the CPP designation is each county. (Cal. Code Regs., tit.10, sec. 2699.6805.)

[3] See Cal. Code Regs., tit.10, sec. 2699.6805

On March 27, 2008 emergency regulations were approved by the Office of Administrative Law (OAL); on August 7, 2008, the Board approved regulation changes to the CPP designation process that changed the scoring methodology for the clinics and CHDP providers. The new methodology considered the volume of services provided by each clinic in the calculation of the clinic score. The regulations also changed the scoring methodology for CHDP providers such that the volume of services provided by the CHDP providers is included in the calculation. The intent of the new methodology was to ensure that higher volume T&SN providers were given a greater weight in the scoring than low volume providers. These regulations became effective on October 22, 2008.

In attempting to implement the new methodology for the 2009-10 benefit year which begins July 1, 2009, MRMIB staff concluded that the calculation of the clinic and CHDP scores cannot be done in conformance with the newly revised regulations. The data sources from which MRMIB develops the CHDP and clinic lists in order to assign percentages to each provider – the Medi-Cal Paid Claims Tape and CHDP Paid Claims Tape - do not include numbers of services provided by each provider.[4] Therefore, MRMIB cannot calculate a score based on the formula contained in the regulations for at least 22 of the 58 counties in California.

Existing regulations require the Board to designate a CPP in each county to be effective on the day the open enrollment transfers described in Section 2699.6621 take effect. The section requires an annual open enrollment period of at least forty-five (45) calendar days. As provided in section 2699.6500(h), the benefit year is defined as the twelve month period commencing July 1 of each year. The CPP designation must be made in sufficient time for the preparation and distribution of information to applicants about which plans will offer the family contribution discount. The information is critical to allow applicants to make informed choices for the next benefit year. As an operational matter, absent extraordinary circumstances, the CPP designation must be made in March and the information distributed to applicants in April.[5]

On February 16, 2009, MRMIB submitted to the Office of Administrative Law (OAL) the request for emergency approval of the proposed regulations. The emergency regulations were approved by OAL and were effective February 26, 2009. The effect of the regulations is described below in connection with the specific subsection modified in these proposed regulations.

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[4] CHDP Paid Claims Tape pursuant to Cal. Code Regs., tit 10, sec 2699.6805(c)(1) and Medi-Cal Paid Claims Tape pursuant to Cal. Code Regs., tit 10, section 2699.6805(c)(2).

[5] As a result of the budget crisis, by statute, for the benefit year 2008-09, the CPP designation was made on a different timeframe. See, Insurance Code section 12693.43. The Board anticipates that for the benefit year 2009-10, the usual timeframe described above will be utilized.

SPECIFIC PURPOSE OF EACH SECTION – GOVERNMENT CODE 11346.2(b)(1)

2699.6805(b).

Section 2699.6805(b) presently requires the Board to compile and make available a list for each county of all CHDP, clinic, and hospital T&SN providers that meet specified criteria by the first day of November. The proposed regulation would change the date when the Board releases the preliminary T&SN provider list. This change gives the Board flexibility as to when the list will be released within the month of November.

2699.6805(c)(2).

Section 2699.6805(c)(2) would remove the requirement that clinics listed on the Medi-Cal Paid Claims Tape provide at least (15) services and replaces it with the requirement that the clinics provide service to at least one child aged (1) through (18). This change reinstates the original method for determining which clinics will be placed on the list. This change is needed because the Medi-Cal Paid Claims Tape does not include data on the number of services provided by clinics that contract with health plans in certain counties.

2699.6805(e).

2699.6805(e) would delete the reference to the "30-day revision period". The 30-day revision period is covered in sections 2699.6805(d)(1), (2) and (3) and is unnecessary in 2699.6806(e). Additional language would clarify the date that the final list will be made available for the 2009-10 benefit year since the change in regulations would occur in the middle of the timeframe described in the present regulations.

2699.6805(f)(4).

2699.6805(f)(4) would be added to adjust the date for when plans must submit the list of the traditional and safety providers in their networks for the 2009-10 benefit year. The language is necessary to clarify the timeframe for the plans' submissions since the proposed change would occur in the middle of the timeframe described in the present regulations.

2699.6805(g)(1).

Section 2699.6805(g)(1) would remove the requirement to use the number of CHDP services provided and changes the methodology for calculating the CHDP

score back to the original method of summing the percentages assigned to CHDP providers based on number of children served. This change is needed because data regarding the number of services provided by CHDP providers is not available for all counties.

2699.6805(g)(2).

2699.6805(g)(2) would reinstate the calculation method for computing the clinic percentage to that which was in effect prior to October 22, 2008. The new method is necessary because the data on number of services by provided by each clinic does not exist for all counties.

2699.6805(g)(2)(A) and (B).

2699.6805(g)(2)(A) and (B) would be deleted and replaced with 2699.6805(g)(2). The change is necessary because the calculation for the clinic score is being changed to the method in effect prior to October 22, 2008.

2699.6805(g)(3).

2699.6805(g)(3) would clarify existing language. Specifically, the language is changed to explain that the percentages are assigned "pursuant to" subsection (c)(3), instead of "described in" the subsection. In addition, the subsection replaces the incorrect reference to (d)(3) with the correct reference to (f)(3).

OTHER REQUIRED SHOWINGS – GOVERNMENT CODE 11346.2(b)(2)-(4)

Studies, Reports, Or Documents Relied Upon: - Gov. Code 11346.2(b)(2)

None.

Reasonable Alternatives Considered – Gov. Code 11346.2(b)(3)(A)

None.

Reasonable Alternatives Considered That Would Lessen the Impact On Small Business – Gov Code 11346.2(b)(3)(B):

None.

Evidence Relied Upon To Support The Initial Determination That the Regulation Will Not have A Significant Adverse Economic Impact On Business – Gov. Code 11346.2(b)(4):

The proposed regulation will not have a significant adverse economic impact upon business.

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CHAPTER 5.8 MANAGED RISK MEDICAL INSURANCE BOARD
HEALTHY FAMILIES PROGRAM
Article 4. Risk Categories and Family Contributions
Amend Section 2699.6805

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Text proposed to be deleted is displayed in ~~strikeout~~ type.

Section 2699.6805 is amended to read:

2699.6805. Designation of Community Provider Plan.

(a) For each benefit year, the Board will designate as the community provider plan in each county the participating health plan with a service area that includes zip codes in which at least eighty-five percent (85%) of the residents of the county reside and that has the highest percentage of traditional and safety net providers pursuant to the calculation in subsection (g) below.

(b) ~~By the first day of~~ In November of the benefit year immediately preceding the benefit year described in subsection (a), the Board shall compile and make available a list for each county of all Child Health and Disability Prevention Program (CHDP), clinic and hospital traditional and safety net providers.

(c) The lists shall be compiled as follows:

(1) The CHDP list shall include all CHDP providers, except for clinical laboratories, that were on the Department of Health Care Services (DHCS) CHDP Master File as of October 1st of the benefit year immediately preceding the benefit year described in subsection (a) and that provided a State-only funded CHDP service as identified on the CHDP Paid Claims Tape to at least one (1) child aged one (1) through eighteen (18) in the state fiscal year that ended immediately prior to the most recently ended state fiscal year. For each listed provider, the list shall indicate the percentage of county children that received State-only funded CHDP services from listed provider. The percentage shall be calculated by dividing the number of county children receiving State-only funded services from the listed provider by the total number of county children receiving State-only funded services from all listed providers in the county.

(2) The clinic list shall include all Community Outpatient Hospital Based Clinics, Rural Health Clinics, Federally Qualified Health Centers, Free Clinics, Community Clinics, Clinics Exempt from Licensure, County Clinics Not With Hospital and County Hospital Outpatient Clinics, in the county, that were so identified by the Medi-Cal program as of October 1st of the benefit year immediately preceding the benefit year described in subsection (a) and were identified on the Medi-Cal Paid Claims Tape as having provided ~~at least (15) services to children~~ at least one (1) service to a child aged one (1) through eighteen (18) in the state fiscal year that ended immediately prior to the most recently ended state fiscal year. The list shall indicate a percentage for each clinic which shall be equal to one (1) divided by the number of listed clinics in the county.

(3) The hospital list shall be compiled as follows:

(A) For a county that has, located in the county, at least one hospital which, as of October 1st of the benefit year immediately preceding the benefit year described in subsection (a), was a hospital eligible for the inpatient disproportionate share hospital payment program as reported by DHCS, a University teaching hospital, a Children's Hospital (as defined in Section 10727 of the Welfare and Institutions Code), or a county owned and operated general acute care hospital, the list shall include all hospitals of one of these types whether or not they are located in the county and which reported to the Office of Statewide Health Planning and Development (OSHPD) discharging at least one resident of the county who was a Medi-Cal, county indigent, or charity care patient aged one (1) through eighteen (18) in the year for which OSHPD most recently released its annual compilation of Discharge Data. The list shall indicate, for each hospital, the percentage of the Medi-Cal, county indigent, and charity care discharges of county residents aged one (1) through eighteen (18) from the listed hospital. The hospital list shall not include acute psychiatric hospitals (as defined in Section 1250(b) of the Health and Safety Code), psychiatric health facilities (as defined in Section 1250.2(a) of the Health and Safety Code), or chemical dependency recovery hospitals (as defined in Section 1250.3(a) of the Health and Safety Code).

(B) For all other counties, the list shall include all hospitals located in the county and all hospitals located outside the county, which, as of October 1st of the benefit year immediately preceding the benefit year described in subsection (a), discharged at least one resident of the county who was a Medi-Cal, county indigent, or charity care

patient aged one (1) through eighteen (18) in the year for which OSHPD most recently released its annual compilation of Discharge Data and which were hospitals eligible for the inpatient disproportionate share hospital payment program as reported by DHCS, a university teaching hospital, a children's hospital (as defined in Section 10727 of the Welfare and Institutions Code), or a county owned and operated general acute care hospital. The list shall indicate, for each hospital, the percentage of the Medi-Cal, county indigent, and charity care discharges of county residents aged one (1) through eighteen (18) from the listed hospital. The hospital list shall not include acute psychiatric hospitals (as defined in Section 1250(b) of the Health and Safety Code), psychiatric health facilities (as defined in Section 1250.2(a) of the Health and Safety Code), or chemical dependency recovery hospitals (as defined in Section 1250.3(a) of the Health and Safety Code).

(d) The lists of CHDP providers, clinics and hospitals described in subsection (c) shall be revised only under the following circumstances:

(1) Any CHDP provider not included on a county list pursuant to subsection (c)(1) or any participating health plan that asserts the CHDP provider met the specified criteria to be on that list and was excluded in error may, within thirty (30) calendar days after the list described in subsection (b) is released by the Board, provide written documentation to the Board demonstrating that the CHDP provider met the criteria described in subsection (c)(1). If the Executive Director of the Board finds that the CHDP provider met the specified criteria then the CHDP provider shall be added to the county list.

(2) Any clinic not included on a county list pursuant to subsection (c)(2) or any participating health plan that asserts the clinic met the specified criteria to be on that list and was excluded in error may, within thirty (30) calendar days after the list described in subsection (b) is released by the Board, provide written documentation to the Board demonstrating that the clinic met the criteria as described in subsection (c)(2). If the Executive Director of the Board finds that the clinic met the specified criteria then the clinic shall be added to the county list.

(3) Any hospital not included on a county list pursuant to subsection (c)(3) or any participating health plan that asserts the hospital met the specified criteria to be on that list and was excluded in error may, within thirty (30) calendar days after the list described in subsection (b) is released by the Board, provide written documentation to the Board demonstrating that the hospital met the criteria described in subsection (c)(3). If the Executive

Director of the Board finds that the hospital met the specified criteria then the hospital shall be added to the county list.

(e) The Board shall compile and make available a final list for each county of ~~Child Health and Disability Prevention (~~CHDP~~)~~, clinic, and hospital traditional and safety net providers after the ~~30-day~~ revision period described in subsection (d) has expired. For the benefit year described in section (a) that commences July 1, 2009 only, the final list shall be the list made available January 22, 2009.

(f) By January 15 of the benefit year immediately preceding the benefit year described in subsection (a), each participating health plan shall submit the following to the Board for each county:

(1) A list of the CHDP providers identified by the Board pursuant to subsection (e) that have a contractual relationship with the participating health plan for the provision of services to program subscribers.

(2) A list of the clinics identified by the Board pursuant to subsection (e) that have a contractual relationship with the participating health plan for the provision of services to program subscribers.

(3) A list of the hospitals identified by the Board pursuant to subsection (e) that have a contractual relationship with the participating health plan for the provision of services to program subscribers.

(4) For the benefit year described in section (a) that commences July 1, 2009 only, the lists described in subsections (f)(1), (2) and (3) shall be those lists submitted by the health plans prior to the effective date of this subsection.

(g) The percentage of traditional and safety net providers in the provider network of each participating health plan will be calculated by summing the CHDP percentage, the clinic percentage, and the hospital percentage.

(1) The CHDP percentage is calculated by summing the ~~number of CHDP services provided to all children aged one (1) through eighteen (18) by listed CHDP providers within the county that were identified by the plan pursuant to (f)(1), and dividing this sum by the number of services provided by all listed CHDP providers in the county~~ percentages assigned to the CHDP providers pursuant to Section (c)(1) that were identified by the plan pursuant to (f)(1), and multiplying that number by 0.35.

(2) The clinic percentage is calculated by~~:~~ summing the percentages assigned to each listed clinic in the county pursuant to subsection (c)(2)

that was identified by the plan pursuant to subsection (f)(2) and multiplying that number by 0.45.

~~(A) Adding the percentages assigned to each listed clinic in the county pursuant to subsection (c)(2) that was identified by the plan pursuant to subsection (f)(2), and multiplying that percentage by 0.225; and adding the number produced by the calculation made in subsection (g)(2)(B) below.~~

~~(B) Dividing the number of services provided by each listed clinic in the county that was identified by the plan pursuant to subsection (f)(2) by the number of services provided by all listed clinics in the county pursuant to subsection (c)(2), and multiplying that percentage by 0.225.~~

(3) The hospital percentage is calculated by summing the percentages assigned to each hospital pursuant to ~~described in~~ subsection (c)(3) ~~assigned to all hospitals in the county~~ identified by the plan pursuant to ~~(d)~~(f)(3), and multiplying that number by 0.2.

(h) The Board shall designate a community provider plan for each county for the benefit year described in subsection (a). Notwithstanding subsection (h) of section 2600.6500, the designation shall take effect on the day the open enrollment transfers described in section 2699.6621 take effect, and the previous designation shall remain in effect until that time. Prior to designation, each plan's relationships with traditional and safety net providers may be verified by the Board.

NOTE: Authority cited: Section 12693.21, Insurance Code. Reference: Sections 12693.21 and 12693.37, Insurance Code.